AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
Request to Medical Provider for Information
Supporting Temporary Accommodation Request

To:
Re: _____ (Patient)
Date:

Dear _____:

I, _____, have submitted a request to the Joint Foremen's Labor Relations Committee (JFLRC) in the Port(s) of _____for accommodations related to a physical or mental impairment.

The collective bargaining agreement governing my employment/potential employment provides for an "interactive process" for evaluating accommodation requests including an independent medical review by an occupational medicine specialist affiliated with _____.

The policy also allows for temporary accommodations while the "interactive process" is in progress upon certification by the employee's/applicant's own health care practitioner of the claimed impairment and need for temporary job accommodations related to the impairment.

I have submitted an accommodation request, and asked for a temporary job accommodation while the accommodation request is pending. The Joint Foremen's LRC therefore requests that you accurately, completely, and promptly fill out and return the enclosed questionnaire to the Joint Foremen's Labor Relations Committee for the Port of _____.

I hereby authorize you to respond to this and any other requests by the Joint Foremen's LRC relating to my accommodation request(s).

Thank you for your assistance in this matter.

I understand that I may revoke this Authorization at any time, in a writing delivered to the JFLRC at: _____. I understand that while my revocation would be effective upon receipt, it will not be effective to the extent anyone has acted in reliance upon this Authorization. I understand that information disclosed pursuant to any health information Authorizations/releases provided to the JFLRC could be re-disclosed by the recipient and no longer be protected by federal confidentiality law, and that state law(s) mayor may not provide additional protections. I may inspect or obtain a copy of this letter and the information I am asked to have used/disclosed.

Dated: _____ _____
Patient Signature

Patient Name (Printed): _____
Registration/Payroll Number: _____
Street Address: _____
City: _____ State: _____ Zip Code:_____
Telephone Number: _____

`Questionnaire for Medical Provider

Date:

Name, Address and Telephone Number of Medical Provider:

Name of Employee:

Relationship of Medical Provider to Employee/Applicant:

1. Date of employee/applicant examination:

2. Reason for visit:

3. Are you the employee's primary health care provider? If so, when did the employee first become your patient?

4. In your opinion, does the employee have a physical or mental impairment that limits his or her ability to engage in one or more major life activity (such as performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, caring for him or herself, and working)? Yes/No (circle one and check activity[ies] affected by impairment below).

□ Caring For Self	□ Walking	□ Hearing	□ Lifting	Other: (describe)
□ Interacting With Others	□ Standing	□ Seeing	□ Sleeping	
□ Performing Manual Tasks	□ Reaching	□ Speaking	□ Concentrating	
□ Breathing	□ Thinking	□ Learning	□ Reproduction	
□ Working	□ Toileting	□ Sitting		

5. If you answered "yes" to number 4, in your opinion, does the employee have any functional limitations or work restrictions due to his or her mental or physical impairment? Yes/No (circle one). If yes, please explain:

(a) What is the impairment causing functional limitations/work restrictions?

(b) Date of onset?

(c) Is the impairment long term or permanent? Yes/No (circle one)

(d) If not, how long is the impairment likely to last?

(e) Please describe the patient's functional limitations or work restrictions.

What, if any, accommodations do you believe would be appropriate?

_____ Date:_____
Medical Provider

WB Temporary Acc Form 3-07